

STATE OF ILLINOIS

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Facility Name & ID Number Manorcare at Palos Hts West# 0041319 Report Period Beginning: 06/01/03 Ending: 05/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>130</u>	Skilled (SNF)	<u>130</u>	<u>47,580</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>130</u>	TOTALS	<u>130</u>	<u>47,580</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>12,558</u>	<u>6,233</u>	<u>16,081</u>	<u>34,872</u>	8
9	SNF/PED					9
10	ICF	<u>5,146</u>	<u>1,087</u>	<u>629</u>	<u>6,862</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>17,704</u>	<u>7,320</u>	<u>16,710</u>	<u>41,734</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 87.71%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)NoneF. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 04/15/96

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter numberof beds certified 110 and days of care provided 13,251Medicare Intermediary CareFirst of Maryland, Inc.

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☐ NO ☒Tax Year: 12/31/04 Fiscal Year: 05/31/04

* All facilities other than governmental must report on the accrual basis.

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Facility Name & ID Number Manorcare at Palos Hts West # 0041319 Report Period Beginning: 06/01/03 Ending: 05/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	251,602	16,706	1,900	270,208	2,422	272,630		272,630		1
2	Food Purchase		181,662		181,662		181,662		181,662		2
3	Housekeeping	136,034	18,241	6,264	160,539		160,539		160,539		3
4	Laundry	34,097	15,914	1,993	52,004		52,004		52,004		4
5	Heat and Other Utilities			183,399	183,399	8,825	192,224		192,224		5
6	Maintenance	42,371	17,662	111,346	171,379		171,379		171,379		6
7	Other (specify):* Medical Waste			439	439		439		439		7
8	TOTAL General Services	464,104	250,185	305,341	1,019,630	11,247	1,030,877		1,030,877		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	2,496,869	198,279	112,291	2,807,439	52,062	2,859,501		2,859,501		10
10a	Therapy	485,156	2,493	34,200	521,849		521,849		521,849		10a
11	Activities	63,083	2,088	5,881	71,052		71,052		71,052		11
12	Social Services	44,833	28		44,861		44,861		44,861		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,089,941	202,888	164,372	3,457,201	52,062	3,509,263		3,509,263		16
	C. General Administration										
17	Administrative	77,853		424,143	501,996	(153,861)	348,135		348,135		17
18	Directors Fees										18
19	Professional Services			14,400	14,400	(3,009)	11,391	(11,391)			19
20	Dues, Fees, Subscriptions & Promotions			116,669	116,669		116,669	(26,255)	90,414		20
21	Clerical & General Office Expenses	322,721	38,816	81,798	443,335	3,009	446,344	(54,696)	391,648		21
22	Employee Benefits & Payroll Taxes			611,859	611,859	58,727	670,586		670,586		22
23	Inservice Training & Education			5,513	5,513		5,513		5,513		23
24	Travel and Seminar			12,109	12,109		12,109		12,109		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			147,459	147,459		147,459		147,459		26
27	Other (specify):* Purchase Service Admin.										27
28	TOTAL General Administration	400,574	38,816	1,413,950	1,853,340	(95,134)	1,758,206	(92,342)	1,665,864		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,954,619	491,889	1,883,663	6,330,171	(31,825)	6,298,346	(92,342)	6,206,004		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

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Facility Name & ID Number Manorcare at Palos Hts West

#0041319

Report Period Beginning:

06/01/03

Ending:

05/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			349,765	349,765	31,825	381,590		381,590			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			7,289	7,289		7,289		7,289			32
33	Real Estate Taxes			333,763	333,763		333,763		333,763			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			86,784	86,784		86,784		86,784			35
36	Other (specify):* G/L Assets											36
37	TOTAL Ownership			777,601	777,601	31,825	809,426		809,426			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			1,599	1,599		1,599		1,599			38
39	Ancillary Service Centers		379,679	85	379,764		379,764		379,764			39
40	Barber and Beauty Shops			26,845	26,845		26,845		26,845			40
41	Coffee and Gift Shops	19,916			19,916		19,916		19,916			41
42	Provider Participation Fee			71,370	71,370		71,370		71,370			42
43	Other (specify):* IV Therapy, Lab, & X-ray		85,750	69,062	154,812		154,812		154,812			43
44	TOTAL Special Cost Centers	19,916	465,429	168,961	654,306		654,306		654,306			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,974,535	957,318	2,830,225	7,762,078		7,762,078	(92,342)	7,669,736			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number Manorcare at Palos Hts West

0041319

Report Period Beginning: 06/01/03

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VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$	10	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals		2		4
5	Telephone, TV & Radio in Resident Rooms	(589)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income		32		10
11	Discounts, Allowances, Rebates & Refunds		21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(319)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		27		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(8,483)	21		18
19	Entertainment				19
20	Contributions	(431)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(11,391)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(40,520)	21		24
25	Fund Raising, Advertising and Promotional	(26,255)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Vending & Misc. Income	(4,354)	21		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (92,342)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (92,342)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	\$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Manorcare at Palos Hts West

ID# 0041319

Report Period Beginning: 06/01/03

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Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Vending Income	\$ (1,030)	21	1
2	Misc. Income	(3,324)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(4,354)		49

Summary A

05/31/04

[illegible]

Summary B

05/31/04

05/31/04

[illegible]

Facility Name & ID Number Manorcare at Palos Hts West# 0041319

Report Period Beginning:

06/01/03

Ending:

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VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Manor Care, Inc.	100	Health Care & Retirement Corporation of America (See H.O. Cost Report)				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3	Cost Per General Ledger	4	5	Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line		Item	Amount		Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	See	Home Office Allocation	\$ 424,143		HCR Manor Care, Inc.	100.00%	\$ 424,143		1
2	V	Page								2
3	V	8								3
4	V									4
5	V									5
6	V	10a	Theapy Management	20,233		Heartland Management Services	100.00%	20,233		6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total			\$ 444,376				\$ 444,376	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

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Facility Name & ID Number Manorcare at Palos Hts West # 0041319 Report Period Beginning: 06/01/03 Ending: 05/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Manorcare at Palos Hts West# 0041319

Report Period Beginning:

06/01/03Ending: 05/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization HCR Manor Care, Inc.Street Address 333 North Summit St.City / State / Zip Code Toledo, OH 43604-2617Phone Number (419) 252-5500Fax Number (419) 254-5495

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	<u>1</u>	<u>Dietary - Direct</u>	<u>Accumulated Cost</u>	<u>2,402,993,349</u>	<u>357 Nurs. Fac</u>	\$	\$	<u>0</u>	1
2	<u>1</u>	<u>Dietary - Pooled</u>	<u>Accumulated Cost</u>	<u>2,860,540,914</u>	<u>357 Nurs. Fac</u>	<u>940,169</u>	<u>509,589</u>	<u>7,368,652</u>	<u>2,422</u>
3	<u>5</u>	<u>Utilities - Direct</u>	<u>Accumulated Cost</u>	<u>2,402,993,349</u>	<u>357 Nurs. Fac</u>	<u>288,728</u>	<u>7,368,652</u>	<u>885</u>	3
4	<u>5</u>	<u>Utilities - Pooled</u>	<u>Accumulated Cost</u>	<u>2,860,540,914</u>	<u>357 Nurs. Fac</u>	<u>3,082,391</u>	<u>7,368,652</u>	<u>7,940</u>	4
5	<u>10</u>	<u>Nursing - Direct</u>	<u>Accumulated Cost</u>	<u>2,402,993,349</u>	<u>357 Nurs. Fac</u>	<u>11,758,547</u>	<u>7,451,541</u>	<u>7,368,652</u>	<u>36,057</u>
6	<u>10</u>	<u>Nursing - Pooled</u>	<u>Accumulated Cost</u>	<u>2,860,540,914</u>	<u>357 Nurs. Fac</u>	<u>6,213,378</u>	<u>3,630,889</u>	<u>7,368,652</u>	<u>16,005</u>
7	<u>17</u>	<u>General & Admin - Direct</u>	<u>Accumulated Cost</u>	<u>2,402,993,349</u>	<u>357 Nurs. Fac</u>	<u>17,137,345</u>	<u>15,146,077</u>	<u>7,368,652</u>	<u>52,551</u>
8	<u>17</u>	<u>General & Admin - Pooled</u>	<u>Accumulated Cost</u>	<u>2,860,540,914</u>	<u>357 Nurs. Fac</u>	<u>84,524,208</u>	<u>36,356,103</u>	<u>7,368,652</u>	<u>217,731</u>
9	<u>22</u>	<u>Employee Benefits - Direct</u>	<u>Accumulated Cost</u>	<u>2,402,993,349</u>	<u>357 Nurs. Fac</u>	<u>4,283,731</u>	<u>7,368,652</u>	<u>7,368,652</u>	<u>13,136</u>
10	<u>22</u>	<u>Employee Benefits - Pooled</u>	<u>Accumulated Cost</u>	<u>2,860,540,914</u>	<u>357 Nurs. Fac</u>	<u>17,698,741</u>	<u>7,368,652</u>	<u>7,368,652</u>	<u>45,591</u>
11	<u>30</u>	<u>Depreciation - Direct</u>	<u>Accumulated Cost</u>	<u>2,402,993,349</u>	<u>357 Nurs. Fac</u>	<u>0</u>	<u>7,368,652</u>	<u>7,368,652</u>	<u>0</u>
12	<u>30</u>	<u>Depreciation - Pooled</u>	<u>Accumulated Cost</u>	<u>2,860,540,914</u>	<u>357 Nurs. Fac</u>	<u>12,354,014</u>	<u>7,368,652</u>	<u>7,368,652</u>	<u>31,825</u>
13									13
14	<u>32</u>	<u>Interest</u>			<u>11,412,188</u>				14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 169,693,440	\$ 63,094,199	\$ 424,143	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$		\$			\$	1
2	National City Bank		X	To fund fixed asset additiona		04/2003	118,340	118,340		6.2743	7,425		2
3													3
4													4
5													5
	Working Capital												
6													6
7													7
8	Interest Income Other											(136)	8
9	TOTAL Facility Related							\$ 118,340	\$ 118,340			\$ 7,289	9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related							\$	\$			\$	14
15	TOTALS (line 9+line14)							\$ 118,340	\$ 118,340			\$ 7,289	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **Manorcare at Palos Hts West**# **0041319** Report Period Beginning: **06/01/03** Ending: **05/31/04****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2003 report.		\$ 266,604	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$ 288,819	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 22,215	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 291,335	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$ 20,213	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 333,763	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1999 304,857	8	
	2000 304,613	9	
	2001 310,944	10	
	2002 296,193	11	
	2003 308,373	12	
Line 2: \$288,819 = \$148,097 for 1st half of 2003 + \$140,722 for 2nd half of 2002			
Line 4: \$291,335 = \$160,277 for 2nd half of 2003 + \$131,059 for Jan-May 2004			
Line 5: \$20,213 is the amount paid to Ernst & Young for their successful 2002 Real Estate appeal.			
The Cook County Assessor and Board of Review granted a reduction in the 2002 assessment.			
		FOR OHF USE ONLY	
	13	FROM R. E. TAX STATEMENT FOR 2003 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
	15	LESS REFUND FROM LINE 6 \$	15
	16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Manorcare at Palos Hts West COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0041319

CONTACT PERSON REGARDING THIS REPORT Gary Geise

TELEPHONE (419)252-5736 FAX #: (419)254-5495

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>23-24-300-132-0000</u>	<u>See attached</u>	\$ <u>308,373.28</u>	\$ <u>308,373.28</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>308,373.28</u>	\$ <u>308,373.28</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

A.

Square Feet:

47,653

B. General Construction Type:

Exterior

Masonry

Frame

Steel

Number of Stories

2

C.

Does the Operating Entity?

☒

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D.

Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☐

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E.

List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F.

Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>1994</u>	<u>\$ 705,000</u>	1
2					2
3	TOTALS			<u>\$ 705,000</u>	3

Facility Name & ID Number Manorcare at Palos Hts West

0041319

Report Period Beginning:

06/01/03

Ending:

05/31/04

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	120			1996	\$ 5,345,094	\$ 133,627		\$ 133,627		\$ 1,081,582	4
5											5
6											6
7											7
8											8
9	Improvement Type**										
10	Current Year Depreciation			1996	398,017	71,533		71,533		373,104	9
11				1997	165,442						10
12				1998	67,765						11
13				1999	27,686						12
14				2000	74,134						13
15	CAMERA SYSTEM			2001	925						14
16	WATER HEATER			2001	9,875						15
17	ARCHITECT COSTS			2001	11,003						16
18	GENERAL CONTRACTOR CONSTRUCTION COSTS			2001	58,199						17
19	EQUIPMENT WIRING & FIRE ALARM			2001	10,645						18
20	VINYL WALLCOVERING & BORDERS			2001	5,307						19
21	WINDOW TREATMENTS			2001	1,918						20
22	CARPET			2001	1,779						21
23	CUBE TRACKS			2001	1,216						22
24	FRENCH DOORS			2001	5,925						23
25	BUILDING PERMIT & LEGAL FEES FOR CONSTRUCTION			2001	7,866						24
26	SITE WORK			2001	14,486						25
27	VINYL WALLCOVERING & BORDERS			2002	1,250						26
28	CARPET, VINYL WALLCOVERING & BORDERS			2002	64,471						27
29	FLOORING IN PUBIC RESTROOM			2003	2,125						28
30	WALLCOVERING & PAINTING			2003	9,129						29
31	DOORS			2003	3,109						30
32	WINDOW TREATMENTS			2003	2,527						31
33	CONSTRUCTION DEPT. COST & INTEREST			2004	12,658						32
34	WALLCOVERING & PAINTING			2004	39,469						33
35	TV ANTENNA JACKS & COAX WIRING			2004	3,140						34
36	DOORS			2004	1,020						35

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 6,346,180	\$ 205,160		\$ 205,160	\$	\$ 1,454,686	70

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,230,616	\$ 144,605	\$ 144,605	\$		\$ 978,530	71
72	Current Year Purchases	172,592						72
73	Fully Depreciated Assets							73
74				31,825	31,825			74
75	TOTALS	\$ 1,403,208	\$ 144,605	\$ 176,430	\$ 31,825		\$ 978,530	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 8,454,388	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 349,765	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 381,590	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 31,825	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,433,216	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☒ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ 86,784 Description: 02 Concentrators, Wheelchairs, Gerichairs, Elct. Beds, Etc.

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2005 \$ _____

13. /2006 \$ _____

14. /2007 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility		2	3	4
		Drop-outs	Completed	Contract	Total	
1	Community College Tuition	\$	\$	\$	\$	
2	Books and Supplies					
3	Classroom Wages (a)					
4	Clinical Wages (b)					
5	In-House Trainer Wages (c)					
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS	\$	\$	\$	\$	
10	SUM OF line 9, col. 1 and 2 (e)	\$				

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8						
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service	Cost	Units	Cost									
1	Licensed Occupational Therapist	10a	4782	hrs	\$	132,708		\$	1,168	4,782	\$	133,876	1		
2	Licensed Speech and Language Development Therapist	10a	1893	hrs		48,149	299		12,213	79		2,192	60,441	2	
3	Licensed Recreational Therapist			hrs										3	
4	Licensed Physical Therapist	10a	4138	hrs		126,125				1,246		4,138	127,371	4	
5	Physician Care			visits										5	
6	Dental Care			visits										6	
7	Work Related Program			hrs										7	
8	Habilitation			hrs										8	
9	Pharmacy	39, 2		# of prescrpts					379,679			379,679		9	
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs											
10	Academic Education			hrs										10	
11	Exceptional Care Program													11	
12														12	
13	Other (specify): Lab & X-ray	43, 3							69,062			69,062		13	
14	TOTAL				\$	306,982	299	\$	81,275	\$	382,172	11,112	\$	770,429	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 54,335	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 181,809)	1,134,927		3
4	Supply Inventory (priced at)	17,857		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	4,851		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,211,970	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	705,000		13
14	Buildings, at Historical Cost	6,346,180		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,403,208		16
17	Accumulated Depreciation (book methods)	(2,433,216)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Construction in Progress	12,266		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 6,033,438	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,245,408	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 110,921	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	273,722		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	291,335		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Payables	103,295		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 779,273	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	118,340		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	3,489		42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 121,829	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 901,102	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 6,344,306	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,245,408	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 6,489,058	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 6,489,058	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	633,043	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 633,043	17
	B. Transfers (Itemize):		
18	Change in Interdivision	(777,795)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (777,795)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 6,344,306	24 *

* This must agree with page 17, line 47.

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 8,046,287	1
2	Discounts and Allowances for all Levels	(2,303,554)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,742,733	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,161,130	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,161,130	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	1,030	12
13	Barber and Beauty Care	29,092	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	589	15
16	Rental of Facility Space		16
17	Sale of Drugs	362,460	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	51,852	19
20	Radiology and X-Ray	38,246	20
21	Other Medical Services		21
22	Laundry	3,394	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 486,663	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc. Income	3,324	28
28a	Late Charges	1,271	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,595	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,395,121	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,019,630	31
32	Health Care	3,457,201	32
33	General Administration	1,853,340	33
	B. Capital Expense		
34	Ownership	777,601	34
	C. Ancillary Expense		
35	Special Cost Centers	582,936	35
36	Provider Participation Fee	71,370	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,762,078	40
41	Income before Income Taxes (line 30 minus line 40)**	633,043	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 633,043	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Manorcare at Palos Hts West# 0041319Report Period Beginning: 06/01/03Ending: 05/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,999	2,152	\$ 70,705	\$ 32.86	1
2	Assistant Director of Nursing	5,290	5,694	154,489	27.13	2
3	Registered Nurses	24,797	26,691	631,584	23.66	3
4	Licensed Practical Nurses	35,856	38,595	738,849	19.14	4
5	Nurse Aides & Orderlies	85,789	92,342	877,206	9.50	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	9,342	10,134	287,808	28.40	7
8	Rehab/Therapy Aides	9,837	10,671	197,348	18.49	8
9	Activity Director	5,764	6,206	63,083	10.16	9
10	Activity Assistants					10
11	Social Service Workers	2,807	3,012	44,833	14.88	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	26,067	27,890	251,602	9.02	15
16	Dishwashers					16
17	Maintenance Workers	2,132	2,296	42,371	18.45	17
18	Housekeepers	14,294	15,378	136,034	8.85	18
19	Laundry	4,378	4,713	34,097	7.23	19
20	Administrator	2,080	2,080	77,853	37.43	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	19,122	20,751	322,721	15.55	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,914	2,065	24,036	11.64	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Hospitality</u>	1,676	1,803	19,916	11.05	33
34	TOTAL (lines 1 - 33)	253,144	272,473	\$ 3,974,535 *	\$ 14.59	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Monthly	12,000	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,680	10, 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 16,680		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	289	\$ 14,385	10, 3	50
51	Licensed Practical Nurses	1,843	68,743	10, 3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	2,132	\$ 83,128		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				Ownership		D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description		Amount	Description		Amount		
Donna Bellocchio	Administrator	0	\$ 77,853	Workers' Compensation Insurance		\$ 63,343	IDPH License Fee		\$ 2,586		
				Unemployment Compensation Insurance		53,323	Advertising: Employee Recruitment		76,549		
				FICA Taxes		286,631	Health Care Worker Background Check (Indicate # of checks performed 243)		4,540		
				Employee Health Insurance		183,035	Dues & Subscriptions		120		
				Employee Meals			Association Dues		5,946		
				Illinois Municipal Retirement Fund (IMRF)*			Advertising		24,422		
				Employee Appreiation		12,613	Public Relations				
				401K		12,341	Relocation		2,506		
				Other Employee Benefits		(3,082)	Less Non-allowable Association Dues		(1,833)		
				Tuition Program			Less: Public Relations Expense		(0		
				SMSP Match		1,163	Non-allowable advertising		(24,422)		
				Employee Uniforms		2,492	Yellow page advertising		(
				Home Office Allocation		58,727	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 90,414		
				TOTAL (agree to Schedule V, line 22, col.8)		\$ 670,586					
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)											
\$ 77,853											
B. Administrative - Other											
Description		Amount									
Management Fees		\$ 424,143									

* Attach copy of IMRF notifications

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

[illegible]

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IHCA \$5946
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes \$1833
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5-10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 60,483 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 71,370
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 0
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? No
Attach invoices and a summary of services for all architect and appraisal fees.